CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Unified Program Integrity Contractor
South Western Jurisdiction (UPICSW)

July 24, 2020

Acute Care Ambulance Service, LLC
1802 Joleigh St.
Mercedes, TX 78570

Re: Notice of Suspension of Medicare Payments
Supplier Medicare ID Number(s): AMB1342
Supplier NPI: 1932471075
Record Identifier: PSP-200617-00004

Dear Acute Care Ambulance Service, LLC:

The purpose of this letter is to notify you of our determination to suspend your Medicare payments pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of your Medicare payments took effect on July 22, 2020 Prior notice of this suspension was not provided, because giving prior notice would place additional Medicare funds at risk and hinder our ability to recover any determined overpayment. *See* 42 C.F.R. § 405.372(a)(3).

The decision to suspend your Medicare payments was made by the Centers for Medicare & Medicaid Services (CMS) through its Central Office. *See* 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. CMS regulations define credible allegations of fraud as an allegation from any source including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability. *See* 42 C.F.R. § 405.370. This suspension may last until resolution of the investigation as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. *See* 42 C.F.R. § 405.372(d)(3)(i)-(ii). Specifically, the suspension of your Medicare payments is based on, but not limited to, information that you misrepresented services billed to the Medicare program. More particularly, a medical review of claims submitted by Acute Care Ambulance Service, LLC determined that Medicare coverage guidelines were not met since the documentation submitted to substantiate the claims failed to describe the beneficiaries' symptoms at the time of transport and that any other means of transportation would be contraindicated. Additionally, beneficiary interviews conducted supported that the ambulance services were not warranted.

The following list of sample claims provide evidence of our findings and serve as a basis for the determination to suspend your Medicare payments:

Claim Control Number (CCN)	Date(s) of Service	Amount Paid	Basis for Selected Claim
452919176129030	06/24/2019-06/24/2019	135.42	Beneficiary interview indicated this

			beneficiary did not qualify for ambulance transports. Additionally, this beneficiary had their claim denied as part of a postpayment medical review because the run sheets that failed to document a detailed objective description of the patient's symptoms and physical findings to support meeting the Medicare requirements for an ambulance service.
452919171505480	06/19/2019-06/19/2019	135.42	The medical records had run sheets that failed to document a detailed objective description of the patient's symptoms and physical findings to support meeting the Medicare requirements for an ambulance service. The run sheet failed to support that any other means of transportation was contraindicated and that the level of medical care of an ambulance service was required.
452919178249360	06/26/2019-06/26/2019	135.42	The medical records had run sheets that failed to document a detailed objective description of the patient's symptoms and physical findings to support meeting the Medicare requirements for an ambulance service. The run sheet failed to support that any other means of transportation was contraindicated and that the level of medical care of an ambulance service was required.
452919176129180	06/24/2019-06/24/2019	135.42	The medical records had run sheets that failed to document a detailed objective description of the patient's symptoms and physical findings to support meeting the Medicare requirements for an ambulance service. The run sheet failed to support that any other means of transportation was contraindicated and that the level of medical care of an ambulance service was required.
452919176129100	06/24/2019-06/24/2019	135.42	Beneficiary interview indicated this beneficiary did not qualify for ambulance transports. Additionally,

			this beneficiary had their claim denied as part of a postpayment medical review because the run sheets that failed to document a detailed objective description of the patient's symptoms and physical findings to support meeting the Medicare requirements for an ambulance service.

This list is not exhaustive or complete in any sense, as the investigation into this matter is continuing. The information is provided by way of example in order to furnish you with adequate notice of the basis for the payment suspension noticed herein.

Pursuant to 42 C.F.R. § 405.372(b)(2), you have the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. We request that you submit this rebuttal statement to us within 15 days. You should include with this statement any evidence you believe is pertinent to your reasons why the suspension should be removed. Your rebuttal statement and any pertinent evidence should be sent to:

Qlarant Integrity Solutions, LLC
Attn: Rebuttal and Suspension Department
14643 Dallas Parkway, Suite 400
Dallas, TX 75254

If you submit a rebuttal statement, we will review that statement (and any supporting documentation) along with other materials associated with the case. Based on a careful review of the information you submit and all other relevant information known to us, we will determine whether the suspension should be removed, modified, or should remain in effect within 15 days of receipt of the complete rebuttal package. However, the suspension of your Medicare funds will continue while your rebuttal package is being reviewed. Thereafter, we will notify you in writing of our determination to continue or remove the suspension and provide specific findings on the conditions upon which the suspension may be continued or removed, as well as an explanatory statement of the determination. *See* 42 C.F.R. § 405.375(b)(2). This determination is not administratively appealable. *See* 42 C.F.R. § 405.375(c).

If the suspension is continued, we will review additional evidence during the suspension period to determine whether claims are payable and/or whether an overpayment exists and, if so, the amount of the overpayment. *See* 42 C.F.R. § 405.372(c). We may need to contact you with specific requests for further information. You will be informed of developments and will be promptly notified of any overpayment determination. Claims will continue to be processed during the suspension period, and you will be notified about bill/claim determinations, including appeal rights regarding any bills/claims that are denied. The payment suspension applies to both current and future payments.

In the event that an overpayment is determined and it is determined that a recoupment of payments under 42 C.F.R. § 405.371(a)(3) should be put into effect, you will receive a separate written notice of the intention to recoup and the reasons. You will be given an opportunity for rebuttal in accordance with 42 C.F.R. § 405.374 from Novitas Solutions, Inc. When the payment suspension has been removed, any money withheld as a result of this action shall be first be applied to reduce or eliminate the determined overpayment and then to reduce any other obligation to CMS or to the U.S. Department of Health and Human Services in accordance with 42 C.F.R. § 405.372(e). In the absence of a legal requirement that the excess be paid to another entity, the excess will be released to you.

Should you have any questions, please contact Christina Cardenas in writing or via telephone at 972-383-000, Ext. 13160.

Sincerely,

S. Scott Ward, CFE, AHFI
Program Director
Qlarant Integrity Solutions, LLC

cc: Centers for Medicare & Medicaid Services